



Shared embarrassment: (not) talking about sex in HIV-related doctor-patient encounters

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Abstract

Prevention with positives (PP) has occupied a central role in HIV prevention strategies since the introduction of effective therapies. International guidelines present counselling in medical settings as an ideal strategy for promoting safer sex practices among people with HIV and AIDS.

Nevertheless, anthropologists and other social scientists have long been putting under intense scrutiny dimensions of power and conflict in the doctor - patient relationship. In this article, PP is analyzed as a biopolitical technology, part of the larger framework of Public Health as a governmental project. Given the present redefinition of HIV prevention priorities amid a deep economic crisis in Spain, it has become urgent to ask to what extent and how sex and prevention becomes an issue in real face to face interaction, and with what effect: what role PP and its absence play in configuring both the “HIV doctor” and the ‘person with HIV’ as specific subjectivities.

Keywords: HIV/AIDS; positive prevention; biopolitics; technology; subjectivity

Introduction: Safer sex as a technology

Public health, as a specific modality of relationship between the State and its citizens (Rose 2006; Rose and Novas 2005), has been conceptualized in the field of the social sciences as a governmental project that is “at the heart of politics nowadays” (Fassin

and Memmi 2004, 10). As part of this larger framework, risk prevention and health education represent a pivotal point of technologies of the self and the politization of the life of the species (Foucault 1977, 2008; Rose 2006). In this respect, it makes sense to approach the practices, techniques, institutions, bodies and subjectivities that we know as HIV prevention, and prevention with positives (PP) as practised in doctor-patient encounters specifically, as *biotechnologies*, “hybrid assemblages of knowledges, instruments, persons, systems of judgement, buildings and spaces, underpinned at the programmatic level by certain presuppositions made about human beings” (Rose 2006, 26; see also Davis 2009; Davis and Squire 2010). PP as biotechnology is part of the process of “making up” HIV-positive subjectivities and bodies (Hacking 2006; Rosengarten 2009). PP also produces a specific form of legitimacy and knowledge around a naturalized entity, HIV transmission, in a manner that is deeply affected by the relationship between doctors and patients in a specific historical and institutional context.

As Menendez (2003) argued, like any scientific discipline or *paradigm*, biomedicine is by definition a universalistic project, but becomes a social and cultural reality when considered as a particular practice, carried out by professionals in particular historical and institutional settings, and in relation to specific social subjects. Biomedicine is neither a monolithical, universal, static enterprise, nor simply a particularistic and personalized practice. As pointed out by Haidar (2009) and Lock and Nguyen (2010), it might be problematic to analyze biotechnologies solely as discursive constructions. Lock and Nguyen (2010) and Reynolds – Whyte (2009) make a strong point when arguing the need to account for the articulation of biotechnologies into concrete practices, without which the program advanced by Rose easily falls into one-sidedness and the same monolithism and universalism that is constitutive in biomedicine. In the

intricacies of practices regarding and surrounding technologies, the actual meanings, objects, morals, and social relations of a specific technology as promoted by experts and as used in specific strategic settings by laypersons (Menéndez 2003) might indeed render the social relevance of medical technologies quite different from those an outsider would expect from the sole consideration of the technical and programmatic discourses underpinning such biotechnological objects and socialities. In a word, we would like to suggest that micropolitical, everyday relations and practices regarding the use of biotechnologies should be taken into account in order to assess their social meaning and political relevance. As Fassin (2007), Biehl (2007) and Petryna (2002) show, the relationship between power and life cannot be read from general legal/institutional arrangements, but its nature must be derived from the concrete form they acquire as they become social practices carried out by social agents in specific historical, political and institutional conditions. Thus, apprehending the social character of medical technologies requires an intensive, ethnographic attention to their social life (Biehl & Moran-Thomas 2009; Reynolds – Whyte 2009).

It has also been argued that medical technologies affect and are in turn affected by patients' subjectivities and subjective strategies (Biehl & Moran-Thomas, 2009). From this perspective, the relationship between lay and expert knowledges, bodies, and selves is transactional in nature and must be captured in specific socio-historical and institutional frameworks (Menéndez 2003; Mol 2008; Pizza 2002, 2005; Rosengarten 2009). Practitioners do value technologies, and make arrangements in doctor-patient encounters that derive not only from the features of technologies themselves, but from learned definitions of the situation and their professional role. Patients are not, as Gramsci said, *trained gorillas* (Pizza 2002). They do not embody technologies

passively, but insert and re-fashion them in strategies that can never be fully predicted from programmatic discourses or the technical arguments that underpin those technologies.

Positive Prevention

Prevention of sexual transmission of HIV is a complex social object (Race 2009; Rosengarten 2009). It involves a set of institutional arrangements, discourses and knowledges, subjectivities, moral economies, subject positions and power hierarchies (Treichler 1999). It unfolds in a specific framework of socio-historical relations, which both affect and are affected by the social object 'prevention'. Prevention of sexual transmission of HIV has seen a steady history of dispute over its specific configuration (Altman 1994; Martin 1994; Patton 1996; Rosengarten 2009). It has involved various stakeholders, both at local and supranational level, whose relations have not been stable (Kippax 2010a).

Historically in Spain, as elsewhere, in the field of HIV tasks had been clearly divided into prevention tasks and treatment tasks. Non-governmental organizations of different natures played a key role in the fight against the spread of HIV infection, carrying the bulk of HIV prevention interventions, especially among the so-called hard to reach populations. National and regional Public Health authorities provided most of the funds and the necessary coordination for the prevention activities of NGOs. Health care providers, until now, had had a less defined role in prevention issues. The expansion of prevention programs that specifically target people living with HIV seems to imply a redefinition of the role of the actors involved. While in the first years of the epidemic

process other tasks (fight against stigma, care, and treatment advocacy) were considered a priority (Davis and Squire 2010), since the advent of ART, if not before, PP has become crucial in the management of the epidemic from a Public Health perspective (Janssen et al. 2001; Wolitsky, Janssen, Onorato et al. 2005). As is known, the role of Health care services in PP is being redefined and expanded, and not without controversy (GNP+ and UNAIDS 2009).

In Spain, the international trend towards the integration of prevention in treatment (Rosengarten 2009) has coincided in time with a weakening of NGOs. In the context of a devastating economic and fiscal crisis in Spain and particularly in the Region of Madrid, the expenditure of public administrations on financing preventive interventions of NGOs has suffered deep cuts, while the role of health care institutions and professionals in HIV prevention is being explicitly expanded (Sevillano 2010). Specifically, in the Region of Madrid, funding for NGO activities and interventions in prevention has been altogether withdrawn. The rationale for this elimination has been that prevention activities should be integrated within existing health structures and programs (primary care and hospitals) in a context of "normalization" of HIV infection and rationalization of state expenditure. Although this is in stark contradiction to recommendations issued by international organizations, we are witnessing a process likely to result in dwarfing the role of community organizations while locating positive prevention and support in health care settings exclusively. HIV should be treated from now on 'like any other disease', de facto putting an end to aids exceptionalism.

In this paper we propose to reflect on these recent developments from the perspective of the implicit consequences of what can be termed a process of medicalization of HIV prevention. While it is not my intention to romanticize the role of community (in fact,

we are well aware of the limitations and shortcomings of the community concept and practice), this paper would like to contribute to current debates about the consequences of the normalization of HIV and the integration of treatment technologies in prevention interventions (Kippax 2010a; Kippax 2010b; Mykhalovskiy and Rosengarten, 2009).

We will present some partial results of a research project financed by the Institute of Public Health of the Region of Madrid, whose objective was to assess the limits and potentialities of doctor - patient encounters in relation to HIV prevention and adherence in hospital units specializing in HIV treatment in Madrid. Fieldwork included 10 sessions of participant observation, with 50 doctor-patient encounters observed over four months and 14 interviews with doctors specializing in HIV treatment in the twelve Madrid hospitals belonging to the public Health system. Thirty interviews with people with HIV in treatment were also conducted, using the criteria of diversification of the sample by gender (16 men, 14 women, including four transgender), age and declared route of infection (7 through heterosexual practices, 10 through homosexual practices and 13 through sharing injection equipment). In what follows we will refer mainly to interviews with doctors and patients.

The absence of positive prevention in doctor-patient encounters

The way different technologies of HIV prevention ("safer sex") and treatment (clinical management of HIV infection) are deployed in the interactional setting of the practice is fundamental in shaping different aspects of the social universe of doctor-patient encounters: the relationship that is established between doctors and patients around (safer) sexual practices, the lived and biological body of people with HIV, the nature of

the relationship between doctors and patients, and the specific power relations forged in doctor-patient encounters. From this starting point we propose an analysis of the practices for promoting safer sex in doctor-patient encounters. We will first describe these practices, and in following sections proceed to their analysis from the perspective of how HIV doctors conceive of their role. Finally we will attempt to understand how this analysis affects the shaping of the relation between doctors and patients.

At first sight, all the clinicians interviewed stressed the importance of promoting safer sex in their interactions with patients. Nevertheless, they considered that their proper remit refers to the 'management of HIV infection', i.e. the control of virus replication in the body and, more generally, keeping the patient in an acceptable health condition.

I work as a physician only seeing patients infected with HIV, I have little to do with primary prevention of infection out there ... well, if someone asks for collaboration I gladly agree... but that is not my primary business. It may have more to do with the job of the primary care physician, keeping people who are not infected from becoming infected ... But nevertheless we do have a very important tool, in that we are the ones who oversee, and monitor and track infected people who are at any given time doing the wrong thing, and can transmit it to the rest of the population. This is very important. Among physicians involved in this there is a clear commitment in this regard. (Md 8)

The importance given to HIV prevention with positives in the discursive level is in stark contrast with observed interactions and with the practices reported by both patients and clinicians. From what the interviewed doctors and patients alike told us, a fairly accurate description of what goes on in the doctor's practice in relation to the promotion of safer sex could be summarized as follows: sexual practices and means of

transmission are intensively addressed in initial doctor-patient encounters, immediately after diagnosis. Patients are given the chance to ask questions to the doctor to spell out any remaining doubts. Also, doctors leave open the possibility of any further questions whenever the patient chooses to at any point in the future. After that, doctors will not address the issue unless they “detect” that the patient is experiencing “troubles with safer sex” or unless explicitly raised by the patient. If we are to go by both doctors and patients and our own observations, this only happens rarely.

For some physicians, this absence of prevention of sexual transmission represents no further contradiction, since prevention is not considered a central part of their specific remit. Others are aware that this limited role in prevention is less than what is required by international standards, which is explained in terms of the need to prioritize time in doctor-patient encounters. In fact, the time allotted to a patient is quite flexible. A certainly demanding workload does not preclude devoting precious extra time to a particular patient, but this happens only as long as it can be *justified*, and this is more likely when strictly medical reasons can be furnished. This also underlines, by way of contrast, the secondary place of prevention in the day to day of the practice. In this regard, the following quote summarizes a critical opinion -expressed in a tone of resignation - of a situation that is perceived as being motivated in part by the excessive workload, but also by the routinization and technification of medical intervention in the management of HIV infection since the introduction of ART, and, as a consequence, of the doctor – patient relationship.

In this environment there is so much pressure to discuss the latest antiretroviral whatnot, the slightest development... I don't mean to trivialize ... But I mean,

the pressure to pay attention to the slightest advance... in ... Lipodystrophy or...
I don't know, whatever ... the latest, slightest development in an obscure paper
... I don't know, what effect this specific medication has on whatever ... So,
this information overload, this approach to the problems of HIV by focusing all
the attention on the medication, even on the part of patients, and on the part of
many NGOs, and of many ... patient associations, right? I mean, the neurosis is
such that it's already ... I think it absorbs all our attention. (Md 6)

In the two instances during observation where the question of prevention of
transmission emerged, it was addressed in a peculiar way: through a display of technical
information about the mechanisms of transmission and the chance of infection, or about
infectivity. In a case of post-exposure prophylaxis, the subject initiated an explanation
of the circumstances of the unsafe practice. The doctor heard what the patient had to say
but did not encourage any further explanations. In the second case, the patient asked for
technical information about HIV transmission, conveying through his tone and gestures
that the motives and circumstances of the unsafe sexual practices were beyond
discussion. Even so, the physician devoted much of the consultation time to "small
talk". Most of the doctors interviewed regarded some of their long-term patients as 'old
friends'. It was not unusual for the doctor to open the interaction by asking them about
their life circumstances, without resorting to a medical "excuse". In what follows I will
explore the productive effects of this striking silence regarding sexuality in doctor-
patient encounters.

Explaining the absence: the concept of medical practice and prevention

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3 In principle, all the clinicians interviewed stressed the importance of promoting safer
4 sex in their encounters with their patients. But what is considered their proper remit
5 refers to the 'management of HIV infection', as suggested above. To understand this
6 paradox it is interesting to note the distinction made by one doctor (Md1) between the
7 "patient" and the "person"; between "the specifically medical" and what he termed "the
8 paramedic". These distinctions replicate the cure / care dichotomy in Medical
9 Anthropology and Sociology.
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20 "We doctors do not only prescribe and diagnose; we listen, we also do
21 supportive psychotherapy." After 15 years of relationship with some of his
22 patients he considers he has "good knowledge" of their personal lives. In this
23 unit, members of staff are open to accepting a "supporting role" from
24 psychologists, but not to be relieved in the management of these aspects. On the
25 other hand, he claims that "in general, we focus on disease, clinical data, and
26 specifically medical things. All the 'paramedical' stuff that every medical
27 activity entails, not only HIV, has to be taken care of because it is part of our
28 day-to-day, but it does not pertain to our formal remit. We insist much more on
29 adherence". He recognizes that he is "biased" towards what are considered
30 medical issues proper. (Md 1)
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45 His work focuses on the patient. Although not ignored, the person is not the center of
46 his activity. This place is occupied by the 'case', a set of reports, records and test results
47 that is set up by the doctor. The *lived body* as experienced and put into play in social
48 interactions is perceived by doctors as a distinct reality whose existence is independent
49 from medical interventions. The relation between the body and the case is nevertheless
50 not adequately grasped as a simple opposition. The 'case' refers to an apparently
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external, objective reality, the organism that it actually materializes (Mol 2002). In turn, the lived body is necessarily constituted in interaction with the ‘case’ as the patient incorporates those records and test results that become part of his/her flesh (Rosengarten 2009). In a parallel manner, the patient – person dichotomy is problematic at least in two senses:

First, from a pragmatic point of view, it is worth noting that the distinction between person and patient has fuzzier boundaries than the representation held by clinicians would predict. The information that doctors collect from their patients, and the attributions they make about them based on preconceptions, are plentiful (Heritage and Maynard 2006). The information they gather from patients in informal contexts plays a role not only in forming a personal relationship with the patient as a ‘person’ (the ‘pact of trust’ between doctors and patients so cherished in medical self-image), but it can also play a role in medical decisions that apparently only affect the case. At any rate, as said before, it is the case that is central, both in clinicians’ representations and in their everyday practice.

Md 5 says he reads "gestures, postures, attitudes," things like whether someone is homosexual, and believes to be right "in 98% of cases." "Not everything in doctor-patient encounters is standardized or protocolized", he says, distancing his discourse from evidence-based medicine. He defends his actions as "interpretations" of criteria, based on what he “reads” in the patient, what he has learned over the years. "You can not have a protocol for each and every situation". The patient's trust in the physician is essential, above all other "influences that he may have". (Md 5)

Secondly, the pre-eminence of clinical management in the doctor-patient relationship is not without effect (Mishler 1984; Waitzkin 1991; Lindenbaum and Lock 1993). On the one hand, it conceals the person by putting him/her in permanent tension with the *case*, because it is ultimately a prerogative of the doctor to decide at what times and circumstances he/she opens a space for the expression of the person, what counts as relevant information, and when to focus solely on the case. As might be expected, the patient perceives this asymmetry and incorporates it and they refrains from giving information about him/herself as he/she anticipates that it will not be considered relevant.

Erm ... He said to me 'You have to take care of yourself, you have to go on a diet and you have to ask the nurse for a list [*with recommendations on foods to eat and to avoid, he notes later*], you have to follow it, you have to take some pills for cholesterol'. I said, 'those pills are expensive and I can not [pay for them]," and he goes, "then you will have to find a way...". I looked at him and said nothing. I thought, I'm quitting, I give up, how am I supposed to explain. I'm unemployed more often than not, you asshole, I'm taking a subsidized course, I have no money to buy expensive medicines.... " It seemed a waste of time to go and explain something that simple. I give up entirely. I did not say anything. It seemed useless to me. (Enrique)

It is the 'case' that legitimates and gives meaning to the position of the health care provider. The promotion of safe sexual practices forces the practitioner to bring out the person beyond the limits of comfort, as it can exceed the field of knowledge that sustains, and confers authority to, the medical intervention. This is so partly because sexuality is a delicate issue in many contexts in our culture, but also because when

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3 talking about patient's sexual intimacy the doctor is not supported by the legitimacy
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5 granted by his/her privileged relation to the 'case', which is after all the doctor's
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7 creation, responsibility and what they were trained for.
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10 The way doctors elaborate on their specific remit with regard to prevention with
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12 positives is consistently built around two central axes: the *basic information* to be
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14 provided to the patient, and the elimination of any *fears* they might have. The basic
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16 information is included in their representations, namely, using condoms, the idea of
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18 superinfection and basic epidemiological information, in other words, the precautions to
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20 be taken in daily life to prevent transmission. Fears are conceived as caused by the
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22 association of HIV with "death and guilt". Fears are understood as the result of a lack of
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24 information, which can be replaced with certainties from scientific knowledge
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26 possessed by health care providers.
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29 The much cited recommendations of the CDC guidelines for counselling in medical
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31 settings rely upon the same narrow concept of health (and individuals' agency, for that
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33 matter) (CDC 2001). Although the authors explicitly advocate an open approach to
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35 counselling, the delimitation of what counts as HIV-related problems to be legitimately
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37 addressed during counselling sessions are ultimately those which can easily be
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39 incorporated to a strictly medical biological narrative of HIV infection, as we can see in
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41 the following recommendation:
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47 "Keep the session focused on HIV risk reduction. Each counseling session
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49 should be tailored to address the personal HIV risk of the client rather than
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51 providing a predetermined set of information. Although counselors must be
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53 willing to address problems that pose barriers to HIV risk reduction (e.g.,
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55 alcohol use in certain situations), counselors should not allow the session to be
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distracted by the client's additional problems unrelated to HIV” (Centers for Disease Control and Prevention 2001)

In the above analysis, it seems clear that different technologies have quite different values. In fact, sexual practices should be framed as "technical" problems for the doctor to embark on a ground on which his/her authority is not guaranteed. In other words, the sexual subject must be reframed to fit to the logic of the 'case'. In the process, HIV transmission is divested from its subjective and sociocultural context, and becomes thus naturalized. The conceptions of disease, infection, and of the role of the physician in regard of his patient are ultimately the tenets of the legitimacy and indeed the viability of the doctor's authority in the doctor-patient relationship.

If the patient is stable and has no problem, the doctor-patient encounter can be what we call a super-fast visit, in other words, the doctor's visit¹ can be very brief. If the patient has a specific problem, then this encounter is stretched out more, and then also depends on the professional you are seeing, not everyone is the same, and some people are not only concerned to see how well you are doing on antiretroviral therapy, CD4 and viral load, but also care about their patients' overall situation. "How are you doing? How's your work? Do you have any problems?" (Md 3)

Concerted discomfort: the patients

¹ This is a Spanish phrase meaning "flying visit", a short and formal visit to a person with whom the visitor has no close acquaintance.

In fact, for most of the people with HIV we interviewed, this lack of reference to sexual practices is not a problem: the representation of what's appropriate in doctor-patient encounters in their view does not differ fundamentally from the clinicians' view as described above. Most patients seem to have incorporated this central element of the framing of the doctor-patient encounter -the agreement on what counts as health and disease, their position in doctor-patient encounters, and the exclusions, silences and invisibilities that are implicitly inscribed in the practice as a social setting. As we just noted, interviewees who express disagreement with doctors in this respect are scarce (Barry et al. 2000).

We consider this a common sense concordance on biomedical definitions of the situation that give an unproblematic appearance to what is a result of a formative/transformative process (Pizza 2005), as clearly manifested in the "negative" cases where this common sense is not unproblematically accepted. The following quote is exceptional as far as the difficulties in discussing sexuality in doctor-patient encounters are thematized.

I came to the determination not to talk about this [sexual issues] with the doctors. Two or three times I tried to broach the subject but it seems to make them uncomfortable, you notice that they are uneasy, and I've had opportunities to gather information through other means, I prefer to make it simpler, more natural... if you see the person is already, well, embarrassed...because it's hard for you [to talk about] any particular practice ... to bring up questions.

(Alfonso)

As for Fede, he agrees that doctors prefer not to address issues that bother them, but spontaneously remembers a situation when addressing his sexuality was necessary from

the point of view of the case, i.e., the problem at issue was an absence of libido as a side effect of medication.

They generally don't ask anything, don't ask about living conditions. In my case, for example, with my doctor, he avoided by all means talking about sexuality. (...) The normal thing would be to ask you how are you doing, if you get an erection, if it has been improving... , but erm, he won't ever mention that point, he doesn't even touch on it. (Fede)

Fede problematizes the absence of addressing his sexuality in doctor-patient encounters in a way that we find highly significant because it displays a particular conception of what is appropriate in doctor-patient encounters which is symmetrical to the doctors' point of view: doubts concerning issues that fall under the field of expertise of biomedicine vs. the impact of HIV stigma on the subject's sexuality. This separation between fields of legitimacy is structural to prevention as technology in doctor-patient encounters, as we have been insisting on. It reproduces a particular construction of what constitutes knowledge about transmission, builds areas of visibility and invisibility in doctor-patient encounters, and supports specific relations of power understood precisely as the ability to define frameworks of legitimacy and relevance (Grimen 2009).

Sometimes, respondents reported a complex set of expectations of expectations. Aurora, a former IDU (injecting drug user) and currently undergoing methadone treatment, aborted on medical advice, but wonders whether she received all the relevant information to make the decision. She thinks the doctor made the decision on the basis of a prejudice about her way of life. In her view, this bias extends to her sexuality in

general, but she made no effort to dispel it, as it would have been useless – or so it seemed to her.

... From the day I had an abortion, even more so since I became this wasted, he assumes I'm... [not having sex]. I can't say it. If he thought of me as normal girl maybe he would ask himself or ... "Got any problems?" But he doesn't say anything, I think he assumes that I will not sleep with anyone.

Interviewer. He is wrong, obviously.

Aurora. (Laughs). At the moment, yes.

She has sexual relations (invisible to the doctor and silenced by herself) with a partner she met on a website (chat room) for people with HIV. They don't use condoms. Andrés, meanwhile, gives an explanation, at the interviewer's request, of why his sexual practices have never come to light again in his encounters with his doctor after the first session, when he was asked about his practices, something he significantly interpreted as exclusively designed to place him in the right statistical category:

Well, as I said I am 75 years old. Sure, seven years ago [when he was diagnosed] I was younger than 75, I guess he thought there was no need to address risky practices, or sexual practices at all, for that matter. (Andres)

Andres brings up again the issue of patients strategically disguising. Like Aurora, he pretends not to notice the judgments based on stereotypes he is subjected to, calling into question the essential but elusive trust between doctor and patient. It is rather a mockery of it, because obviously the illusion of trust is based upon the patient's interpretation of the physician's expectations as he/she tries to accommodate to them. From all this

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3 disguising the doctor is very likely to have no clue at all. Elisa makes a similar point as
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5 she explains why she avoids giving the doctor information she knows he does not 'want
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7 to hear'. She also has unprotected sex, although in this case with a serodiscordant
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9 partner, a Sub-Saharan black man.
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14 Why? He [the doctor] is not going to believe ... that he's sleeping with me
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16 without a condom and has not been infected. He is not going to believe it, so,
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18 why would I tell him? (Laughs) Let him be happy, thinking whatever he
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20 wants. It's because doctors don't want to know certain things. They think
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22 ... everything has to be straight and clear, and do not put the will of the person
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24 into the equation, do not take it into account ... [Interviewer: What are those
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26 things doctors do not want to know?] E: Erm ... anything that's not
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28 ... "scientific" [ironically]. (Elisa)
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33 Raul has a partner who has HIV. Since he widowed, he has always chosen his sexual
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35 partners from among women with HIV, and when he has a stable partner as he has now,
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37 he does not use condoms. He knows "it is wrong", but:
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42 ... As I say, why would I say anything if they're going to give me hell? ... You
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44 take the risks because that is also something that has to do with your freedom...
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46 (Raul)
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51 However, it must be stressed that the most common situation is that patients feel
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53 comfortable with the described situation and consider perfectly acceptable that doctors
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55 only talk about (safer) sex in the first encounter(s), nor do they question the tone of
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57 scientific authority they use with the purpose of filling potential gaps of
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information. Transactions involving the person, their experience and their life contexts, are common, as noted above. However, when it comes to preventing sexual transmission of HIV, there is what might be called a *concerted discomfort*.

In a few cases patients problematized the difficulty of raising sexuality issues relevant from their point of view. These patients perceived their doctor's uneasiness when it came to talking about sexuality. Sometimes they even detected their doctor's preconceptions about their own sexuality or sexual practices. Nevertheless, it never emerged as a conflictive issue during encounters.

Patients seem to prefer to deploy what might be termed strategic disguising (Faizang 2005): they are well aware of the limits of what can be legitimately addressed in their interactions with doctors. They are also aware of their doctor's implicit expectations about their sexuality in general and safer practices more specifically, but they don't defy them: they rather accommodate to the situation as it comes. In this case, the trust that allegedly characterizes the doctor-patient relationship turns out to be more of game of mutual delusions and disguising in which the patient simply acts as he perceives he is expected to.

Conclusions

The tendency to "integrate" prevention services into "normalised" health care services reinforces the trend towards normalisation already detected in 2000 by Rosenbrock and colleagues. It signals the end of 'exceptionalism' and a return to *business as usual* in the management of the HIV epidemic, as it is increasingly addressed like any other disease, with all the pitfalls and shortcomings this can entail (Kippax 2010a and 2010b). The normalisation of HIV in this sense questions the broader alliances between activists,

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3 public health experts, and health care providers that characterised the first decades of
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5 the epidemic. It is true that the recommendations of the CDC, often cited as a rationale
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7 for integration policies, do not imply the disappearance of other agents. However, the
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9 uncritical assumption of the argument that medical settings are particularly suitable for
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11 PP interventions, though based on a common sense conception of trust between doctors
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13 and patients, and attractive and flattering as it may be for health care professionals, may
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15 eventually lead to a medicalisation and de-socialisation of PP which will render it quite
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17 ineffective in supporting People living with HIV.
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21 In Spain, with the economic crisis calling every priority into question, at the core of the
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23 integration of prevention in settings where treatment is provided, is a case of “lifeboat
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25 ethics” (Scheper Hughes 1993), where the biopolitical role of the state is redefined in
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27 terms of determining what is absolutely indispensable and what should be left to private
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29 interest or undone. Although it has never been argued that clinicians should play an
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31 exclusive role in HIV prevention, at least in Madrid, the role of NGO’s has been
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33 evaluated as more dispensable than the clinicians’ in a context of deep fiscal crisis.
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37 The absence of PP in day-to-day transactions in the surgery is fraught with
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39 consequences. The familiarity that supposedly characterises the doctor-patient
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41 relationship (‘wishful thinking’ according to Grimen 2009) is rather a concerted
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43 framework of implicit assumptions that tend to leave invisible a large part of the
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45 experience with sex and stigma of people living with HIV – everything that can’t be
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47 expressed in medical terms. As has been clearly established (see Delor, 2000, Grimberg
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49 2009), however, risk practices are understood only in reference to complex life contexts,
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51 and people living with HIV keep unsafe practices for reasons that go far beyond the lack
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53 of information, which cannot be a problem generally among a population highly
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55 exposed to, and with every reason to actively seek, ‘basic information’.
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As a result, our interviewees deal with the bulk of what really matters to them outside medical settings. Nevertheless, prevention with positives, because of its absence and the presuppositions it entails, tends to construct and reinforce a set of power relations, discourses and subject positions to which people living with HIV must unavoidably react. In most cases, this absence is naturalised as mutual and self fulfilling expectations among patients and clinicians about what is proper in their relationship; in some cases, it gives pace to muted but quite intense conflict. In either case, patients will incorporate over time in a practical way in their relationship with doctors the idea that the 'right' way to handle these issues is in terms of a demand for technical information, assuming that (1) 'subjective' difficulties to maintain safer sex practices are not relevant in doctor-patient encounters, and (2) that the patient must assume a subordinate role in his/her relationship with his/her doctor when it comes to sexuality, as he/she has been dispossessed of the possibility of agency in establishing what is relevant and what is not regarding his/her sexuality with their doctor. It seems clear that prevention with positives functions as a powerful governmental technology, although not as expected by the technical discourses of HIV prevention. In this sense, the context in which prevention with positives is inserted determines its concrete form and value. Taking this context into account ethnographically is fundamental for its interpretation and qualification. Strictly medical technologies impose their own logic upon prevention, prioritising specific ways of knowing, viewed as a less central, medical technology and as practised in the context of treatment. Different technologies might have different values. PP as practised by doctors in Madrid renders PLHIV's strategic interventions unintelligible and invisible. In the best of cases, this turns prevention into disciplining orthopaedics; in the worst of cases it leads to unattended suffering.

Finally, talking more in terms of what should happen than what in fact happens in doctor-patient encounters, the obvious question is whether medical settings are the adequate scenario to conduct a more democratic, less rigid strategy to foster safer sex among positives; whether a change in the power relations that underpin the doctor-patient encounter is possible or even desirable at all. Doctors' authority must play a role in contexts where medical knowledge is fundamental; in other contexts, like those where the subjective strategies of people living with HIV are at issue, power differentials are such formidable obstacles that one is left to wonder if they might be overcome; moreover, they represent a framework that tends to produce an extremely restricted and medicalised version of HIV prevention that denies the lived experiences of people living with HIV and the socio-political contexts in which they are forged.

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